histaminic cephalgia, Sluder's neuralgia and others.[15] The mechanism of this disorder probably involves intracranial arterial vasodilatation. It occurs predominantly in men, whereas migraine most often occurs in women (Table 4). It starts in the fourth and fifth decade, whereas migraine begins in childhood through the third decade. Cluster headaches characteristically waken people from sleep. They are associated with eye pain that is generally nonpulsatile in quality and are not usually associated with scintillating scotomata or vomiting. Often they are associated with tearing and reddening of the eye, puffiness of the periorbital tissue, stuffiness of the nose ipsilaterally and as the pain wears off in 10 to 20 minutes—these are short bursts of pain—the nose begins to run. All of these occur on the same side as the pain. The attacks occur one to several times per day for several weeks, stop for a while, and then recur. This cluster tempo is distinctive. There is no diminution of platelet serotonin in this condition; nor does there tend to be a high familial prevalence of the condition, as there does in migraine. These disorders are quite different genetically, clinically and biochemically. Yet the same group of drugs is effective for all of these patients.

What we have called migraine today is strictly an operational gesture. Your patients will benefit from your recognition of this common problem. In the not too distant future, several different disorders with distinctive mechanisms will probably emerge from this patient population. Until then, let us all keep our minds open regarding the nature of this disorder. We have certainly come a long way from the notion that migraine is primarily a psychosomatic disorder, a prevalent view 20 years ago.

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Presence of Abscess

In general, the problem of pus for the surgeon is the problem of diagnosing the cause of unexplained fever. After we have gone through the regular ritual of looking at the urine, looking at the lungs, looking at the wound and looking for phlebitis, one of the common causes of fever today, we are ready to consider abdominal abscess. I make it a cardinal point in my practice never to explore the abdomen or the chest looking for an abscess that I have not already found with a needle or by palpation, feeling a mass in the abdomen. I never explore for an abscess. I have got to find it. And the way to find it is by repeated, careful, deliberate, systematic physical examination by the same observer several times a day, every day. It is the fever that is the tipoff to the presence of the abscess. The leukocyte count helps me not at all.

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